Bedfordshire Clinical Commissioning Group

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Review of Tier 3 Child and Adolescent Mental Health Services (CAMHS)

1. Introduction, Background, Aim and Review Methodology

Acknowledgement

Bedfordshire Clinical Commissioning Group (BCCG) would like to take the opportunity to thank all those who took part in this process and the time invested to make this happen.

Introduction:

Definitions of the Tiers of Community adolescent mental health services (CAMHS) services can be found below.

Definitions of Tiers of Child and Adolescent Mental Health Services:

Tier 1: Social, emotional and developmental support from professionals outside specialist CAMHS, as part of their everyday work that generates resilience and prevents mental health problems (e.g. teachers, social workers, SEN workers, Health visitors, school nurses and GPs).

Tier 2: Any specialist CAMHS workers using individual professional skills with children and families (e.g. primary mental health workers, psychologists and counsellors working in community and primary care settings.

Tier 3: Specialist CAMHS workers working in specialist therapeutic teams in community mental health clinics or child psychiatry outpatient service (known as Core CAMHS)

Tier 4: Highly specialist teams working in day and in-patient units providing services to children and young people with the most serious problems (this is commissioned by National Commissioning Board, specialised commissioning team (SCT).

The tiers are based on the CAMHS four-tier strategic framework, which was laid out in 1995 Health Administration System (HAS) and is widely used.

NB From 1st April 2013, the responsibility for commissioning tier 4 services lies with the National Commissioning Board, specialised commissioning team.

CAMHS are a comprehensive range of services that provide help, assessment and treatment to children and young people experiencing emotional or behavioural difficulties, or mental health problems, disorders and illnesses. Referral is through professionals such as GPs, social workers and educational psychologists. More details about CAMHS services can be found elsewhere in this report. CAMHS services are described in tiers, and used to explain the nature of the presenting condition and the service received. There are four tiers, tier 1 is described as a universal service for children and young people with low level need – tier 4 is used to describe very specialist services used by a small number of children and young people.

BCCG commission tiers 2 and 3 CAMHS services, local authority's commission services generally at tiers 1 and 2, whilst NHS England is responsible for commissioning specialist services at tier 4.

In order to inform the development of a revised service specification and model of services delivery for tier 3 CAMHS, Bedfordshire Clinical Commissioning Group (BCCG) has undertaken a review of tier 3 CAMHS as currently provided. This report sets out the scope and methodology used to complete the review, and highlights findings and recommendations.

A separate review of Tiers 1 and 2 has been completed by Public Health for both local authority areas. The aim of which was to examine and evaluate the Tier 1 and Tier 2 CAMHS service provision in Bedfordshire and identify information to inform future commissioning of services. This included collecting service providers and local stakeholder's views on local services, gaps and areas for improvement. The review produced a final report and recommendations presented to the Commissioning Officers Group at Bedford Borough Council (BBC) and the Acting Early Group in Central Bedfordshire Council (CBC). A full copy of the findings and recommendations from this review are attached in Appendix 1 and 2 of this report. The BCCG are members of the review project team in each local authority area.

This report of the tier 3 review does not intend to repeat the findings and issues raised within the Public Health Review but considers appropriate recommendations for Tier 3 commissioning and issues to be addressed as part of a potential overall strategy for CAMHS across Bedfordshire.

NATIONAL PERSPECTIVE

Health outcomes matter to patients and the public. The White Paper: 'Liberating the NHS' outlined the Coalition Government's intention to move the NHS away from focusing on process targets to measuring health outcomes. The annual NHS Outcomes Framework reflects the White Paper vision and contains a range of indicators to provide a balanced coverage of NHS activity. Its purpose is to:

- provide a national level overview of how well the NHS is performing;

- provide an accountability mechanism between the Secretary of State for Health and the NHS Commissioning Board for the effective spend of some £95 bn of public money; and
- act as a catalyst for driving up quality throughout the NHS by encouraging a change in culture and behaviour.

LOCAL PERSPECTIVE

Bedfordshire CCG is developing its vision for Children's services. This will be based on an integrated partnership multi-disciplinary approach to all community based services. This work will reflect NHS England's and Operating Framework 14/15 vision of integrated working between health and social care. Children's services both in and outside our hospitals are also being reviewed and a model will be developed to support the vision, which will include the integration of community and hospital services. With this in mind it is expected that CAMHS model will be developed in line with this approach over the coming months and years to ensure a strategic fit within this vision.

Aims:

The aim of the review was to ensure that Bedfordshire Clinical Commissioning Group:-

- Looks at the needs and intervention required to meet the needs of children and young people rather than diagnosis.
- Looks at the current gaps in service and issues within the delivery of Tier 3 CAMHS in Bedfordshire and makes recommendations for improvements which support the tier 1 and 2 pathway.
- Focuses on BCCG responsibilities as the lead commissioners of Tier 3 services.
- Focuses on availability, location, waiting time, flexibility and staffing of the service to children and young people and their family.
- Enables an effective, seamless patient journey through clear pathway/tiers.
- Provides continuous improvement and outcome based service specification, specifying functions which meet the needs of children and young people with a mental health issue in Bedfordshire.

As Commissioners, to deliver outcomes, we need to ensure that these points are embedded within our service specifications, quality/performance monitoring and management arrangements.

Background:

In Bedfordshire, the responsibility for providing tier 3 services is with Bedfordshire Clinical Commissioning Group (BCCG), who has commissioned South Essex

Partnership Trust (SEPT) to deliver these services; working in partnership with local authorities and other providers (who deliver tier 1 & 2). The budget for the tier 3 CAMHS services commissioned by BCCG is approximately £4.1m for 2013/14

The Benchmarking Network data released in November 2013 allows us to compare data and statistics with other CAMHS provided across England. The data produced makes comparisons across a range of indicators per 100,000 population, Bedfordshire has a 0-17 year old population of approximately 100,000.

Through this comparison, we can directly compare the level of funding the local CAMHS services gets with other providers. The tier 3 CAMHS service commissioned in Bedfordshire falls in the top quartile for investment for 0-17yrs for 100,000 population, i.e. Bedfordshire is in the top 25 %

The CGG has made this comparison on tier 3 services only – the national benchmarking data could include tiers 1 and 2 if covered by the same provider. This means that the budget provided to SEPT for tier 3 services per 100,000 could in fact be more in comparison than other areas if they have includes other tiers in their submission.

Therefore at this stage, it is not envisaged that there will be any further financial investment as a result of completing the review, and any changes to services will be met within the resource envelope held.

For 2013/14 SEPT, has been commissioned to deliver 13,233 direct contacts (e.g. face-to-face contact or significant consultation with service users/parent) and 1,045 in-direct contacts (such as consultation with professionals) for tier 3 CAMHS.

SEPT has included an indicative figure of £40,000 savings in the Cost Improvement Plan for 2013/14.

The BCCG currently commission the following Tier 3 services from SEPT with each team/functions having a separate service specification. These teams are as follows:-

Core CAMHS Team (Tier 3 / Specialist CAMHS)

The objective of this service is to address the needs of children, young people their families and carers presenting with moderate to severe mental health problems by:-

- Supporting them to develop problem solving skills.
- Developing parents' and carers' ability to manage existing psychological problems more effectively.
- Enhancing children and young people's coping abilities.
- Having a positive impact on the child or young person's resilience to assist them manage negative stress more effectively.

- Providing evidence based clinical interventions to treat diagnosed Mental Health disorders/illnesses, where appropriate.

The service operates from **9am** to **5pm** and there are three teams based at the **Bedford Borough, South and Mid Bedfordshire.**

Learning Disability Team

The objective of this service is to provide an integrated service to children up to the age of 18 years, who have a learning disability, complex neuropsychiatric needs associated with challenging behavioural problems and moderate to severe mental health problems. The service operates from **9am** to **5 pm** and the team is based in Bedford, but covers Bedfordshire.

Home Treatment Team (HTT)

The objective of this service is to ensure that young people with a high level of mental health needs have access to appropriate and effective treatment and in particular to reduce pressure and increase capacity in the current Tier 3 services to undertake planned work and reducing the number of CAMHS inpatient bed days (Tier 4). It does this by providing a local highly specialist alternative to inpatient service for children and young people up to the age of 18. This includes a focus on:

- Maintaining young people with severe mental health needs safely within their community focusing on a service around the individual and family.
- Providing intensive evidence-based treatment on an outreach basis and an extended service including evenings, weekends and 24 hour on call for crisis resolution.
- Assessing all children and young people who potentially require inpatient admission.
- Facilitating planned early discharge where appropriate.
- Working closely with other services including the Core specialist CAMHS team and education and social care teams using a care pathway approach.
- Ensuring that high intensive treatment and support is as short term as possible with the transfer of services back to the Core specialist services as soon as is medically appropriate.

The service operates from:-

During weekday normal office hours all elements of the service to be available

During weekdays 5pm to 10pm provision of home support and an on call service

During weekends 9am to 10pm provision of home support and on call service

There is 24/7 support via a telephone helpline and adult CR/HT

Tier 2 Services:

In addition, BCCG also commissions Tier 2 services from a range of providers - CHUMS, Relate, Open Door and Sorted. CHUMS are the largest tier 2 provider commissioned by BCCG (they are commissioned to provide interventions to 66 new referrals per month). Further details of all the Tier 2 services commissioned by BCCG along with all commissioned services across both tiers 1 and 2, can be found in the Public Health report on the findings and recommendations of the review of CAMHS Tiers 1 and 2 – at Appendix 1 and 2.

Review Methodology

There has been input from a range of stakeholders to identify issues with current service provision, gaps and areas for improvement. Key steps in the project included:

- An initial scoping meeting with appropriate key stakeholders which included local authorities and SEPT.
- Initial feedback from the Children Young People and Maternity Services Programme Board.
- Summary of information on estimated local need for CAMHS services provided by Public Health.
- Data from service providers including SEPT and CHUMS.
- Consultation meetings with service providers (SEPT and CHUMS), including clinicians, Team and Senior Managers.
- Discussions with local authority senior managers from Bedford Borough and Central Bedfordshire Councils.
- Benchmarking of other reviews of CAMHS undertaken elsewhere.
- NHS Benchmarking network information data, November 2013.
- NICE guidance and recommendations in relation to Tier 3 Mental Health Services Guideline - **Referral, Assessment and coordination of care and Treatment considerations in all settings to include** Psychological therapies used in the treatment of children and young people should be provided by therapists who are also trained child and adolescent mental healthcare professionals.
- Results of a questionnaire circulated to all GPs and Local Authority Social Workers/Children’s Services staff. (See Appendix 3)

It is intended that as part of the next phase of the project, service users, parents and carers will be consulted on the finding of this report.

2. Summary of Findings

2.1 Access

Needs of the Bedfordshire population:

Mental Health:-The prevalence estimates for different mental health disorders, broken down by age for Bedfordshire are detailed below. Please note that any child may have more than one disorder. (Source ONS 2001.)

National and Estimated Local Prevalence of Emotional Disorders by Age Bands

Age band (years)	Bedfordshire Population Estimate (2010-11)	National Prevalence in 2004		Estimated local absolute number* (BCCG)	
		Anxiety Disorders	Depressive Disorder	Anxiety Disorders	Depressive Disorders
5-10 yrs old	29500	2.20%	0.20%	649	59
11-16 yrs old	30,680	4.40%	1.40%	1350	429
5-16 yrs old	60,180	3.30%	0.90%	1986	541

National and Estimated Local Prevalence of Conduct Disorders by Age Bands

Age band (years)	Bedfordshire Population Estimate (2010-11)	National Prevalence in 2004	Estimated local absolute number* (Bedford Borough)	Estimated local absolute number* (Central Bedfordshire)	Estimated local absolute number*(BCCG)
5-10 yrs old	29,500	4.90%	549	897	1446
11-16 yrs old	30,680	6.60%	803	1,222	2025
5-16 yrs old	60,180	5.80%	1355	2136	3490

National and Estimated Local Prevalence of Hyperkinetic Disorders by Age Bands

Age band (years)	Bedfordshire Population Estimate (2010-11)	National Prevalence in 2004	Estimated local absolute numbers *

5-10 yrs old	29,500	1.60%	472
11-16 yrs old	30,680	1.40%	429
5-16 yrs old	60,180	1.50%	902

National and Estimated Local Prevalence of Eating Disorders by Age Bands

Age band (years)	National Prevalence in 2004	Estimated local absolute number* (Bedford Borough)	Estimated local absolute number* (Central Bedfordshire)	Estimated local absolute number (BCCG)*
5-10 yrs old	0.30%	34	55	89
11-16 yrs old	0.40%	49	74	123
5-16 yrs old	0.30%	70	110	180

National and Estimated Local Prevalence of Autism Spectrum Disorders by Age Bands

Age band (years)	National Prevalence in 2004	Bedfordshire Population Estimate (2010-2011)	Estimated local absolute number (BCCG)*
5-10 yrs old	1.00%	29500	295
11-16 yrs old	0.80%	30680	245
5-16 yrs old	0.90%	60180	541

National and Estimated Local Prevalence of Psychotic Disorders

Age band (years)	National Prevalence	Bedfordshire Population Estimate (2010-2011)	Estimated local absolute number (BCCG)*
5-18 years	70,460	0.40%	282

Source: National estimate from NICE, applied to local population estimate

Source: Child and Maternity Health Observatory (CHIMAT) Data: Self-harm for 0-17

Year	CHIMAT Self-harm for 0-17 year
2010-2011	154
2011-2012	74

Local Self-harm Data: Numbers of Emergency Admissions for Intentional Self-harm for 10-17 year olds (2008-2011) in BCCG

Year	Intentional Self-harm for 10-17 year olds within BCCG
2008-2009	71
2009-2010	70
2010-2011	100

* Estimates are based on local population numbers (rounded figures). National Estimate from Mental Health of Children and Young People in Great Britain 2004

Source: NHS Bedfordshire (Bedfordshire Clinical Commission Group) Mental Health Assessment

Learning Disabilities: The prevalence estimates for learning disabilities in Bedfordshire are detailed below. Please note that any child may have more than one disorder.

The known prevalence rate of a learning disability as defined above is 3% of children. Of these 0.3% have a severe learning disability, with a high likeliness of complex health needs. There are 700,000 children with disabilities, under the age of 16, in the UK – this data includes children with physical disabilities who do not have a learning disability. (Family Resources Survey, 2002-2003). Of these up to 6,000 children living at home are dependent on assistive technology (including ventilators

Age band (years)	National Prevalence	Bedfordshire Population Estimate	Estimated local absolute number (BCCG)*
0-18 years	3%	120,360	3611

Prevalence of complex health needs in the population of children with learning disabilities is increasing, with an expected increase in levels of severe learning disabilities of about 1% per annum, with an overall increase of 10% by 2020.

Data from SEPT contract management informs us that in April 2012 to March 2013 SEPT received 2568 referrals, 2030 of these were accepted.

Currently there is no data outlining the needs of those receiving SEPT services, or other Tier 2 services which we provide such as the nature of diagnosis or the reasons for receiving CAMHS treatment.

It is anticipated that the future introduction of Payment By Results and the clustering (of needs) processes could be used to identify the number of service users treated, allocating each patient to a classification system and agreeing what should be provided for people in each cluster. This information could be used to help identify the appropriate number of cases within each CAMHS tier.

From data provided by SEPT – Funding for Core CAMHS is £2.583m and the number of contacts per annum for Core CAMHS is 12,440 (2013/14 data).The estimated cost per contact is £208 per contact. However the national average is £220 per contact.

The cost of tier 2 per contact in Bedfordshire is £95.

Eligibility Criteria:

Feedback from SEPT clinicians and senior Managers identified the following as gaps within the current commissioning arrangements. This will need continuous service development and will be included within the new service specification:

- Sexualised behaviour (psychosocial assessments and treatment reducing harm to others and the community).
- Eating disorders (early referrals with up to date record of weight, BMI also indication if weight lost how much and how quickly also any physical investigation and the results thereof etc.).
- Forensic Service (to address the needs of young people who display anti-social, high risk and/or offending behaviour e.g. arson etc.).
- A need for family based interventions and support especially as research indicates that many children with a mental health disorder will also have parents with mental health issues. For example, CHUMS data suggests that 50% of children referred to their emotional health and wellbeing service also have a parent with a mental health issue.
- Paediatric psychology – currently there is only 1 post based at the Luton and Dunstable Hospital. However, it is anticipated that this issue will be picked up as part of the review of paediatric services.
- SEPT(Tier 3) and other Tier 2 providers have also highlighted a rise in the number of complex cases, leading to an increase in-direct work such as liaising with social workers. Although the recent withdrawal of Social worker posts in SEPT (Bedford Borough) may also be a factor in this issue. In April 12 to March 13, there was 2042 in-direct contacts with SEPT (16%) compared to 12440 (84%) direct contacts.
- Moving between tiers - this has been consistently raised as an issue. Feedback from professionals and stakeholders have emphasised that when users do not meet criteria for tier 3 but they need more than 4 sessions, where do they go? There are a significant number of cases referred from tier 3 to tier 2, which indicates that the pathway is not very clear to those referring and those using the services. This is further supported by the recent CAMHS Benchmark data.
- The results of a questionnaire circulated to GPs and Social Workers/Children's Services professionals in both Bedford Borough and Central Bedfordshire Council found that referrals are being rejected as patients do not meet the threshold for Tier 3 services; this was an important issue for professionals.
- From the recent NHS CAMHS benchmarking data it was apparent that there are disproportional national average numbers of medical, clinical psychologist,

operational managers, administrational and support workers compared to other Trust average.

The above information tells us that in order to ensure that the needs of children and young people are met quickly and smoothly we need to redefine the pathway, review the composition and grading of the workforce and possibly reduce the number of teams from 3 to 2, supported by up skilled-staff and administration to take on and support cases with complex needs. There is also a need to integrate the 3 functions in tier 3 into a single service specification, ensuring that services are based on intervention required to meet the needs of individuals and not diagnosis. Discussions with local authorities suggests that there could be better integration of the CAMHS LD team with local authorities and development of a prioritisation model to manage crisis and prevention as well as high cost placements. These would enable evidence based outcomes for young people. The creation of two teams on local authority boundaries will enable this.

Recommendations:

- In order to ensure that this need is met and people receive appropriate referral and treatment, more work was required by all partners (including local authorities) to identify the actual numbers of cases required for commissioning across all CAMHS tiers (1-3) to meet local need.
- Develop a new outcome based single service specification for SEPT based on meeting the needs identified and not diagnosis including parental support, sexualised behaviour, eating disorders, forensic services etc.
- Redefine Tier 3 and ensure seamless service specification between tiers to avoid any gaps.
- SEPT to review and act upon their workforce, skill mix profile and professional training.
- Need to set the contacts/ activities to reflect the spending, ready for the contract variation.
- Reduce the numbers of Core CAMHS teams from three to two to realign with local authority boundaries and integrate CAMH Tier 3 services with provide a seamless service for children and young people which reflects their health and social care needs.

2.2 Patient Journey:

BCCG commission tiers 2 and 3 and Local Authorities have responsibility for commissioning 1 and 2. The tier 1and 2 review was not able to establish how many children and young people fall in tier 1 and 2, therefore we need to look at how many cases are and should be should be within the tiers, and this will need to be done by working with partners, including local authorities and providers.

At present there are many CAMHS providers in tier 2, this can make the journey very complicated resulting in users and professionals making referrals to all services, including Tier 3. Therefore for referrers and for service users we need to ensure that there is a single entry point into CAMHS to allow streamlining, and better co-ordination in the service users journey. This is supported by the findings of the questionnaires circulated to GPs and Social Workers/Children's Services. Common themes identified through the responses were focused on:

- the importance of earlier access to services (such as a reduction in the current waiting times);
- earlier intervention; and
- a joined up approach across all relevant services (health, social work and education/schools) including better communication between agencies at different tiers to meet the mental health needs of children and young people.

It would be beneficial to benchmark service areas looking at a whole tier approach to CAMHS as part of developing a strategic and holistic patient journey and developing pathways with partners to ensure children and young people get the right treatment at the right time. This needs to be embedded into an overall CAMHS strategy for Bedfordshire.

Recommendations:

- Develop a pathway of care across all tiers to ensure coherent patient journey across providers and tiers. This should include Tier 4 specialist commissioning.
- Develop a CAMHS strategy across Bedfordshire.

2.3 Referrals:

Against their commissioned target, SEPT is currently over performing. Data provided by SEPT clearly identifies that the number of referrals accepted is the same as the number of referrals received. Anecdotal evidence (letters from the service to commissioners, findings of tier 3 review and conversations with clinicians) suggests that there are a number of inappropriate referrals to the service (perhaps as much as a third of referrals are more appropriate for tier 1 and tier 2 services).

Anecdotally there is evidence that GPs and other professionals make more than one referral and make inappropriate referrals as there is limited knowledge about the providers with clear criteria about what should be referred under which tier. Across the children's workforce, there is a lack of knowledge about where to refer to and how across different tiers.

Stepping up and down between tiers 2 and 3 has issues too – e.g. between CHUMS and SEPT. There is a need to ensure that people enter the system at the correct tier and therefore get timely appropriate treatment.

These points were supported by the findings of the questionnaire circulated to GPs and Social Workers/Children's Services where a number of challenges to making referrals were raised. This included the lack of a single point of access, absence of clarity and knowledge about referral criteria and services available locally and the high number of rejections received due to the current Tier 3 criteria. However, a small number of respondents also mentioned that the process of making referrals to SEPT had improved or that it was positive or good.

From the national benchmark data it is indicated that over 60% of SEPT services do not use prioritisation criteria. Data from the national benchmarking exercise also highlighted that in 2012/13 SEPT received 2,005 referrals per 100,000 population – and accepted 1,357 of these referrals

Recommendations:

- Develop a Single Point of Access and communicate to users and professionals how it works. Ensure that they can refer in an appropriate manner. It was reported that for a Single Point of Access to operate effectively, the professional would have to be appropriately trained, skilled and knowledgeable.
- There are currently too many CAMHS providers resulting in duplication, and confusion for those entering the system and those referring. Therefore we need to stream line, redefine clear pathways and pool the money for better outcomes and VFM.
- Improve monitoring of rejected referrals including obtaining more consistent data is required from SEPT to understand and monitor these as on-going issues.

2.4 Waiting Times

The results of the questionnaire outlined that the ability of the tier 2 and 3 CAMHS to assess and treat the service user quickly is highly desired by professionals and commissioners.

It was notable that this was not considered to be the case at present, with many respondents highlighting instances of significant waiting times for CAMHS. 73% of

GPs and 69% of Social Workers/Children's Services professionals who responded did not feel that the current waiting time was appropriate with a significant theme throughout the responses on the need to reduce waiting times. However, it was felt by some that there needs to be a flexible response which should be based on need/urgency of the child presenting with mental health problems.

What did become apparent was that the waiting time as indicated by SEPT, is from referral to assessment **but** there is further waiting time from assessment to treatment. On average the waiting time from referral to assessment is 10 weeks and a further 20 weeks from assessment to treatment, which equals 30 weeks.

The BCCG have stated that it is their intention that by 2015, we expect that 100% of children and young people referred to tier 3 CAMHS will be seen and where appropriate treatment started within 6 weeks.

Data from SEPT analysed at the end of quarter 2, 2013/14 indicates that the average length of treatment is 30.5 weeks. However it was apparent that length of treatment varied from team to team, Dunstable averaging 55 weeks compared to North Bedfordshire averaging at 16 weeks.

Recommendations:

- Explore reducing waiting times from referral to assessment and assessment to treatment as part of CQUIN, along with reducing repeat referrals.
- To monitor referral to assessment and assessment to treatment as part of SEPT contract monitoring.
- Clinicians from SEPT should be supported by their organisation to discharge cases back to GPs or back to referees at the end of their treatment, thus creating a throughput and reducing waiting times.
- The length of treatment should be reduced thus allowing new referrals to be assessed, treated and discharged quickly.

2.5 Providing Choice and Flexibility (Location and appointment times):

- Currently, the SEPT Core CAMHS Teams work across three locations, two sites in Bedford and one in Dunstable. SEPT offer some flexibility on where appointments are held e.g. outreach work, and clinics, however, they should build on this further.
- The accessibility of Beech Close site in Dunstable can be a challenge particularly for those coming from Leighton Buzzard as it can be 50 minutes on a bus and children and their families may have weekly or fortnightly sessions. Accessibility increased as an issue for this team when they moved to Beech Close from a more central location in Dunstable. There could be merit in exploring a move to a more central location and/or undertake more outreach work.

- The Mid Bedfordshire team are based in Bedford rather than in Mid Bedfordshire.
- There was a notable difference in responses to our questionnaire, showing that half the respondents wanted different times for both non-urgent assessment and treatment, across the 3 teams in Bedfordshire and half thought that current arrangements were adequate.
- The availability of services outside of working hours would be beneficial for those service users who have to attend school, college, or work during the hours of 9:00am to 5:00pm on weekdays. This was a theme within the responses to the questionnaire circulated to professionals.
- From the GP and Social work questionnaire, when asked *where should the most appropriate location for specialist CAMHS services for non-urgent treatment be?*, the location which received the most votes was for a local and accessible CAMHS unit/clinic. There was also broad support for other locations including GP Practice/Health Centre, School, home and community venue (e.g. local Children's Centre).
- Professionals believed that it should be possible for a level of flexibility to be built into the service, based on the need of the child. This would allow service users to be seen when and where they choose.
- There is a need for consultation with children, young people and their parents/carers on access to services.

Recommendation:

- More outreach work is required based on consultation with children and their families/carers, as well as asking questions at the beginning of their initial assessment about what their needs are in terms of location and timings. This should include exploring options of using alternative venues e.g. GPs surgeries/Health Centre, School, home and community venue (e.g. local Children's Centre) etc.

2.6. Providing a High Quality Service:

- Findings from the questionnaire circulated to professionals highlighted that **SEPT Tier 3 provide a quality service** to the children and young people who meet their criteria.
- **Appointment booking and Did Not Attend (DNA)** – From the current local data, DNA rate for Quarter 2 in 2013 is 13% for the CAMHS Core Team, in comparison with benchmarking average is also 13%. This places us in the top quartile, however the bottom quartile is 9%. Therefore, reducing DNAs (particularly within the Core Teams) would create additional capacity within the current service. More work could be undertaken to benchmark with other areas, the possible use of text messaging reminders etc. it is recommended that SEPT undertake an audit in this area and identify solutions.

- **Case Co-ordinator/communication with children, young people teams** - Feedback from SEPT suggests that there is a need for a case co-ordinator to work alongside therapists to provide consistency and communication. Often extra time is being spent on in-direct work and does not maximise the effective use of resources.
- **Implementation of an IT system** – There is still a great emphasis on paper work and duplication in relation to information gathering, completion of the CAF, and assessment by tiers repeating the same question.
- **Home Treatment Team** – At present the response time is 4 hours from referral to assessment. Often this is too long for children and young people and their families, commissioners may need to consider reducing the response time to 2 hours. The questionnaire for professionals raised the importance of easy access to the crisis support (delivered by the Home Treatment Team) including over a weekend or evening/night.
- **Transitions to adult services** – Some cases are held by clinicians after their 18th birthday. Clinicians inform us that this is due to lack of appropriate treatment or not meeting the adult criteria/ threshold for services. Data provided by SEPT from the Care Plus System in early October 2013 outlined that there were 98 transition cases of 18 year olds plus being held by Core CAMHS, HTT and Looked After Children's Teams. 16 of these cases had no plan to close/or identified transition arrangements. Commissioners need to ensure that SEPT continues to undertake an annual audit of transitions to ensure on-going discharge or transfer to adult services.
- **Workforce to meet present and future needs** -from the recent NHS benchmarking data which is for SEPT CAMHS including Essex and Luton, Workforce makeup/pay band is unclear for Bedfordshire, however it was apparent that there are discrepancies :-

High numbers of the following:

- ✓ Medical staffing on average with other NHS providers is 8.86 fte compared to SEPT which was 11.43 fte
- ✓ Clinical psychologists on average is 11.58fte compared to SEPT 19.92fte
- ✓ Operational Mangers on average 2.6fte compared to SEPT 4.60fte
- ✓ Mental health therapist on average is11.68fte compared to SEPT at 17.69fte

Low numbers of the following:

- ✓ Administration staff on average 19.30fte compared to SEPT 6.56fte
- ✓ Support worker on average at 2.17fte compared to Zero employed by SEPT

- Training of other health, social care, education, patient and carers was on average is 80% compared to 10 % by SEPT

- In general the workforce skill mix in relation to Bandings was limited.

Recommendations:

- Explore the nature of DNA through undertaking an audit and looking at possible ways to reduce these.
- Jointly develop an integrated multidisciplinary working to deliver tiers 1, 2, 3 services.
- Reduce the HTT 4 hour target from referral to assessment to 2 hours in the service specification to ensure easy access to crisis support.
- Explore integrated IT systems to reduce duplication and increase efficiency.
- Ensure that SEPT undertake an annual transitions audit this should include ensuring that post 17 years cases are smoothly discharged or transferred to adults as per transition protocol.
- Review the workforce and realign with CAMHS benchmarking profile, reconfiguration of teams and up skill staff.

3. Service Specification for Tier 3 CAMHS

BCCG currently commission Tier 3 CAMHS services from SEPT with three separate service specifications for each individual team, Core CAMHS, Home Treatment and Learning Disability teams.

To deliver the Government's vision of outcome based commissioning set out the White Paper: Liberating the NHS and the NHS Outcomes Framework, the BCCG need to develop an outcome based service specification which reflects both the NHS Outcomes Framework and the development of outcome measures being developed as part of the implementation of Children and Young Peoples' IAPT. Detailed outcome measures need to be included within the new service specification.

The development of a single specification for the Tier 3 CAMHS service would reduce any potential for silo working and help focus on the delivery of outcomes which commissioners would like the service to deliver. Respondents to the professional questionnaire raised communication between SEPT teams as an issue, which could have an impact on referrals and treatment.

Although BCCG commission Tier 3 services for significant mental health issues, there is anecdotal evidence that referrals are made to both tier 3 and tier 2 providers (such as CHUMS, Relate) simultaneously to ensure quick and timely access into assessment and treatment. Therefore there may be double counting.

An amended draft service specification will incorporate the relevant recommendations from this review with clear outcomes.

The recommendations below are combination of recommendations from tier 1, 2 and 3 reviews. This will help us to develop the seamless and robust CAMHS Strategy.

Recommendations for the CAMHS Service.	*Tiers*
1. Develop a pathway for child and adolescent mental health services, with a single referral route where appropriate (e.g. through the early help CAF service) – for all tiers.	All
2. There are too many providers and it is confusing for the child and their family to move through the system. Need to consider pooling the budget together, streamline the pathway and reducing duplication in the services.	All
3. Develop a standard template to be used for monitoring/evaluation of child mental health and wellbeing services to include information about outcomes, quality, client feedback and breaking down service user information by local authority area.	All
4. Raise awareness of existing Tier 1 and 2 child mental health and wellbeing services locally.	All
5. Develop an emotional health and wellbeing (CAMHS) strategy for Bedfordshire, to be reported to the Children's Partnership Board and CYP and maternity services programme board.	All
6. Develop a pathway of care across all tiers – coherent patient journey across providers and tiers. This should include Tier 4 specialist commissioning.	All
7. In order to ensure that this need is met and people receive appropriate referral and treatment, more work was required by all partners (including local authorities) to identify the numbers contacts required for commissioning across all CAMHS tiers (1-3) to meet local need.	All
8. Develop a new outcome based single service specification for SEPT Tier 3 service based on meeting the needs identified and not diagnosis including parental support, sexualised behaviour, eating disorders, forensic services etc.	3
9. Redefine/Redesign Tier 3 and ensure seamless service specification between tiers to avoid any gaps.	2&3
10. Need to set the contacts/ activities to reflect the spending, ready for the contract variation.	3
11. Ensure that GPs can refer in an appropriate manner, it was reported that for a Single Point of Access to operate effectively, the staff would have to be appropriately trained, skilled and knowledgeable.	All
12. Improve monitoring of rejected referrals.	2 & 3
13. Monitor the referral to assessment and the assessment to treatment and repeat referrals as part of contract monitoring	2&3
14. Explore monitoring and reduce waiting times from referral to assessment and assessment to treatment as part of CQUIN.	2&3
15. Clinicians should be support by the organisation to reduce length of treatment and discharge cases back to GPs or back to referrals at the end of their treatment, thus creating a throughput and reducing waiting time.	3
16. More outreach work based on consultation with children, as well as asking question at the beginning of their initial assessment about what	2&3

their needs are in terms of location and timings– explore options of using alternative venues e.g. GPs surgeries, Library etc.	
17. Explore nature of DNA through undertaking an audit and looking at possible ways to reduce these.	2&3
18. Reduce the HTT[1] 4 hour target from referral to assessment to 2 hours in the service specification.	3
19. Jointly develop an integrated multidisciplinary working to deliver tiers 1,2,3	All
20. Explore integrated IT system to reduce duplication and increase efficiency.	All
21. Ensure that SEPT undertake an annual transitions audit this should include ensuring that post 18 years cases are smoothly discharged or transferred to adults as per transition protocol.	3
22. Further work needed in relation to capacity, effectiveness of the tier 3 workforce and around a need to up-skill staff to meet the new challenging demands.	3
23. Reduce the number of Core CAMHS team (Tier 3) from three to two to ensure better consistency and throughput. This will realign CAMHS Tier 3 services with local authority boundaries to provide an integrated and seamless service for children and young people which reflects their health and social care needs.	3

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